INITIAL ASSESSMENT

Visit Date ________________________, 200 _______ PT accompanied by ________________________________

M.D. ____ Referring MD ________________________________

Other ____

LANGUAGE ISSUES ☐ Professional translator present *(name)* ________________________________

Start ______________ ☐ Other translator present *(please specify)* ________________________________

End ______________ ☐ Language phone line used

CHIEF COMPLAINT ____

(Required: be specific and descriptive)

PRESENT ILLNESS ____

DIABETES HX Date dx ______________ Date OHA started ______________ Date insulin started ______________

DKA ☐ Y ☐ N Severe Hypoglycemia ☐ Y ☐ N Loc ☐ Y ☐ N ↓ Symptoms BG ______________

INSULIN DOSE _____ - _____ - _____ - _______ (u/day __________ u/k/day __________) Brand __________________

Static, Algorithm Pump _________ Basals _________ Target BS _________ Ins CHO _________ CF _________

MEAL PLANNING Calories ______________

Schedule: Arise ___________ Breakfast ___________ Lunch ___________ Supper ___________ Bed ___________

Snacks ________________________ Last RD ________________________ Last TN ____________________

EXERCISE Type/Frequency ____

LAST EYE EXAM Date/Findings: ____

MONITORING

Frequency ____ Log book ☐ Y ☐ N

Blood: Monitor used ______________________________ Visual/Meter - technique reviewed _________________ *(date)*

Pre B	Post B	Pre L	Post L	Pre D	Pre Sn	HS	MN – 3 a	4-7 am

Urine: Ketones ____ Glucose ________________________________

The information contained in this message is intended for the exclusive use of the addressee or addressee's authorized agent. This message is privileged and confidential or may contain proprietary or sensitive information. It shall not be copied or disseminated except as directed by the addressee. Any unauthorized use, copying or dissemination of this message or its contents is prohibited. If you have received this fax in error, please advise the sender immediately and return this message and any copies to our office immediately.

JOSLIN DIABETES CENTER AFFILIATE at St. Vincent Charity Hospital

Phone: 216-363-3301 Fax: 216-363-3304

ST. VINCENT CHARITY
MEDICAL CENTER

2351 EAST 22ND STREET
CLEVELAND, OH 44115
stvincentcharity.com
A Ministry of the Sisters of Charity Health System

PATIENT LABEL

MR.JDCIA

SVPOD-126 (2/05)

ALLERGIES ____________________

MEDICATIONS ____________________

FAMILY HISTORY ____________________

SOCIAL HISTORY

Smoking ☐ Y (amount ________/day) ☐ N

Alcohol ☐ Y (amount ________ /wk) ☐ N

CULTURAL INFLUENCES ____________________

OCCUPATION ____________________

LIST PREVIOUS HOSPITALIZATIONS ____________________

PAST MEDICAL - SURGICAL HISTORY ____________________

RISK FACTORS Premature CAD ☐ Y ☐ N Hypertension ☐ Y ☐ N Lipid problems ☐ Y ☐ N Cancer ____________

PATIENT LABEL

Visit Date ____________________________, 200 _______

REVIEW OF SYSTEMS

	☒ = WNL	Pertinent positives/negatives
Constitutional	☐	
Endocrine	☐	
Eyes	☐	
ENT/Oral	☐	
Cardiovascular	☐	
Pulmonary	☐	
Gastrointestinal	☐	
Urinary	☐	
Reproductive	☐	
Musculoskeletal	☐	
Integumentary	☐	
Neurological	☐	
Psychiatric	☐	
Hematologic	☐	

PHYSICAL EXAM

Height: __________ Temp. ___________

Weight: __________ Resp. ___________

BP:		Lying	Sitting	Standing
Right	_____	____ / ____	____ / ____	____ / ____
Left	_____	____ / ____	____ / ____	____ / ____
Pulse	_____			

General Appearance

HENT

Eyes

Neck/Thyroid

Lungs

Heart

Breasts

Abdomen

Rectal

GU/pelvic

Extremities/spine

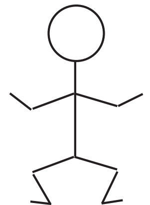
Pulses	R	L
Carotid		
Fem		
POP		
DP		
PT		

Integument

Injection sites

Finger tips

Reflexes



Foot Exam
- ☐ DP/PT pulses strong and bilateral
- ☐ Normal pin
- ☐ Normal toe vibration
- ☐ Normal monofilament
- ☐ No ulcers present
- ☐ Skin intact

Skin

Neuro

Mental status

CN

Cerebellar

Sensory

Motor

The information contained in this message is intended for the exclusive use of the addressee or addressee's authorized agent. This message is privileged and confidential or may contain proprietary or sensitive information. It shall not be copied or disseminated except as directed by the addressee. Any unauthorized use, copying or dissemination of this message or its contents is prohibited. If you have received this fax in error, please advise the sender immediately and return this message and any copies to our office immediately.

JOSLIN DIABETES CENTER AFFILIATE at St. Vincent Charity Hospital

Phone: 216-363-3301 Fax: 216-363-3304

ST. VINCENT CHARITY
MEDICAL CENTER

2351 EAST 22ND STREET
CLEVELAND, OH 44115
stvincentcharity.com
A Ministry of the Sisters of Charity Health System

PATIENT LABEL

MR.JDCIA

Total time spent counseling patient/family ____________ min.
Total time spent with patient ____________ min.

EKG ______________________________ Hemoglobin A1c ______________________________

COUNSELING *Counseled patient on the following:*

☒ Check appropriate box

- ☐ Risk/benefit oral agents vs. insulin
- ☐ Risk/benefit new medication
- ☐ Smoke cessation
- ☐ Side effects of medications
- ☐ BP management
- ☐ ↓ BS management
- ☐ Intensive insulin Rx
- ☐ Driving
- ☐ Hypoglycemia
- ☐ Risk-taking behaviors
- ☐ Child dev. & behavioral issues
- ☐ Pubertal issues
- ☐ Menopause
- ☐ Sexual function
- ☐ Sexuality
- ☐ Diabetic nephropathy

Pathophysiology of:

- ☐ Thyroid function
- ☐ Diabetes
- ☐ Celiac

Please indicate specifics discussed with patient: ______________________________

ASSESSMENT/PLAN/GOALS ______________________________

FOLLOW-UP ☐ Eye ☐ Renal ☐ RD ☐ Mental health ☐ TN ☐ Exercise ☐ Podiatry ☐ Other ____________

Resident/Fellow ______________________________ *Non-supervising provider* ______________________________

PROVIDER REVIEW & CO-SIGNER

☐ On this day I saw, examined and was physicially present with the resident for key portions of the services provided. I agree with the resident/fellow plan and notes. I would add the following remarks:

OR

☐ I have seen the patient, reveiwed the note of Dr. ______________________________ and would add the following remarks to the key portions of the note:

TEACHING PHYSICIAN NOTE:

History ______________________________

Physical exam ______________________________

Medical decision-making ______________________________

Supervising physician ______________________________

PATIENT LABEL